# FUNDING FLEXIBILITY FOR MENTAL HEALTH SERVICES

Prepared for the

**HJR 35 Subcommittee**

by

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# EXECUTIVE SUMMARY

The interim subcommittee of the Legislative Finance Committee (HJR 35 subcommittee) studying public mental health services has adopted development of appropriate community mental health services as its primary study focus. The HJR 35 subcommittee has heard repeated testimony that one of the impediments in developing and delivering appropriate community mental health services is the inflexibility in public funding streams.

Service providers, state and local agency personnel, and mentally ill persons and their families have described some situations where the type of community services desired by adults and children needing services, their families, providers, and state and local agencies either cannot be made available or cannot be paid for because of restrictions that accompany funding sources. The HJR 35 subcommittee heard testimony that funding inflexibility can: 1) block use of appropriate community services to prevent hospitalization of some adults and children and other out-of-home placement of some children; 2) sometimes cause disagreement among service systems as to which system should fund services for children and adults with more than one diagnosis or for children and adults who are involved with more than one public agency or entity; and 3) in some instances, cause persons to lose eligibility for services when family incomes have actually declined. The HJR 35 subcommittee has heard testimony that flexibility to buy unique services is a key component in the ability of providers to maintain adults with a severe and disabling mental illness in the community and children who are seriously emotionally disturbed in their families.

## Purpose of the Report

The purpose of this report is to determine how funding barriers can be lessened or eliminated. A related purpose is identification of alternative funding sources to either: 1) provide additional or innovative community services to persons with mental health needs; or 2) offset current general fund costs to free up general fund to use in developing new, innovative community services. Arguably, adding other funding sources to support mental health services, particularly a federal funding source, is somewhat contradictory to the primary purpose of creating funding flexibility. However, identification of all possible funding sources and related policy issues is important to legislative knowledge and decision making by both the legislature and executive branch.

An additional purpose of the report, which arose as a result of researching funding flexibility, is a legislative oversight issue. The Department of Public Health and Human Services (DPHHS) has used Medicaid funds for pilot and demonstration projects that limited provider participation and statewide availability of services without necessary waivers of federal criteria and without following applicable federal procurement guidelines, all potential violations of federal Medicaid criteria.

## Mental Health Services Funding

Federal Medicaid funds support the largest share of the cost of public mental health services, followed by general fund and then federal Children's Health Insurance Program (CHIP) funds. Medicaid services are funded 70 percent federal funds and 30 percent general fund while CHIP is funded 80 percent federally with a 20 percent general fund match. General fund and a federal block grant of about $1 million support the Mental Health Services Plan (MHSP). Eligibility for all publicly funded mental health services is based on family income and in some instances existence of a severe and disabling mental illness in adults and serious emotional disturbance (SED) in children.

Each program pays for unique services and has service limitations tied to individual funding streams.[1] Since access to each program depends on income, and in some case impairment, it can be cumbersome to fund appropriate, unique services to maintain adults and children in the community. In their testimony to the HJR 35 subcommittee, providing services in the community, when appropriate, is a goal endorsed by state agencies, service providers, and persons needing mental health services, their families and advocates.

The HJR 35 subcommittee has received several suggestions to help eliminate inflexibility of funding sources and to help foster development of appropriate community services: 1) fund services with a captitated or case rate;[2] 2) create ways to fund wrap around services that may be outside the scope of services covered by a traditional fee-for-service system; 3) increase general fund to cover service gaps not funded by other programs; and 4) allow each community flexibility to develop programs suited to its needs. These suggestions were used in evaluating methods of creating more flexibility in funding community mental health services.

## General Fund

General fund is the most flexible funding source. States can design programs, constrained only by federal and state constitutions and laws. However, there is usually more demand for general fund than availability. A significant component of the state

[1] Eligibility for each state funded program, access to services, and types of services covered are discussed in more detail in a report prepared by the Legislative Fiscal Division called "A Thumbnail Sketch of State Funding for Public Mental Health Services and Eligibility for and Access to Services" written in January 2000.

[2] A capitated payment is a per member per month method of reimbursement for health care programs. A participating health care provider agrees to provide certain or all health care services for persons eligible for the health care plan for a fixed, known fee. In Medicaid programs, capitation rates usually vary by the age and disability of the eligible person. A case rate is a fixed payment for services for an individual for a fixed time period that could be greater than one month. Case rates can also vary by age and disability of the person. Depending on the individual health plan, both methods of reimbursement can include stop loss provisions, but do shift a certain amount of risk to health care providers, as the cost of services may surpass the fixed reimbursement for some cases.

public mental health system, the MHSP, is funded almost entirely from general fund. (The $1 million federal mental health services block grant is also included in the MHSP.) Montana will receive a settlement from the national lawsuit against tobacco companies. Tobacco settlement funds are mentioned here because they are currently deposited to the general fund. General fund revenues related to tobacco settlement monies could also be used to fund mental health services. The state could receive between $60 to $70 million in the 2003 biennium from settlement funds. As with other general fund revenues, tobacco settlement proceeds will be highly sought after by various interest groups.

## Medicaid Funding

The most significant source of funding for state public mental health services is federal Medicaid funding. Once a state opts into Medicaid, its program must meet certain federal criteria: 1) program participants must have freedom of choice among providers; 2) any willing provider meeting program criteria must be able to participate in the program, unless the state follows the federal procurement guidelines to select and award bids competitively; and 3) services must be available statewide (to the extent providers are willing to participate). If a state wishes to bypass any of these federal criteria, it must get a waiver or it will be out of compliance with federal Medicaid criteria. However, it appears that a state can never waive compliance with federal procurement criteria if it wishes to limit the number of providers that can deliver a Medicaid service.

If a state is found to be out of compliance, it will have a period of time to implement corrective actions to come back into compliance and most probably avoid a sanction. If a state does not comply with federal Medicaid criteria, it can be fined all or part of the federal financial participation in its Medicaid program.

States can create flexibility in program design, reimbursement methods, and limit provider participation using Medicaid waivers. But the waiver process can be time consuming, both to develop programs and administer the waiver and, depending on program design, approval of the waiver can take more than two years.

States can use a prepaid health plan (PHP) to develop flexibility in funding and providing services within Medicaid programs. A PHP must be funded with a capitated rate and may include services in addition to those approved in the state Medicaid plan. A PHP can also include fewer services than those approved in the state Medicaid plan. States can avoid waivers and compliance with the federal procurement process if any willing provider can participate in the PHP and if consumers have a choice to participate either in the PHP or in the traditional fee-for-service system. Federal review of PHPs is not required if the total contract reimbursement is less than $1 million per individual provider.

If Medicaid consumer participation in a PHP is voluntary it may result in adverse selection, especially if the PHP includes a comprehensive array of services. Voluntary

participation may pose financial risks for both the state and the provider, depending on plan design.

Changes made by Senate Bill (SB) 534 passed by the 1999 legislature could limit provider participation in a PHP. SB 534 requires providers participating in a Medicaid managed care plan to be a licensed insurance carrier.

A PHP holds promise to provide funding flexibility for Medicaid services. However, it must be designed carefully if a state wishes to avoid obtaining a waiver of federal Medicaid criteria, bypass federal procurement criteria, and be funded adequately. Additionally, the provisions included in SB 534 may apply to a PHP.

## CHIP

Most children eligible for MHSP would also be eligible for CHIP. MHSP has a richer array of services than CHIP, so when a dual eligible child needs services not covered by CHIP, those services are covered by MHSP. Since CHIP is funded 80 percent from federal funds and 20 percent from the general fund while MHSP is supported primarily from the general fund, covering MHSP costs from CHIP can offset current general fund outlays.

CHIP is funded from a fixed federal grant, currently authorized for ten years, but with federal funding allocated for five years. States have three years after the grant is received to fully expend grant funds for services.

DPHHS anticipated that CHIP would cover about 10,200 children each year of the 2001 biennium. There were 3,700 children enrolled in CHIP at the end of February 2000, with enrollment expected to increase 600 to 700 children per month.[3] At those projected rates, December 2000 is the earliest that full CHIP enrollment could be attained.

The state CHIP plan, which has received federal approval, would allow federal CHIP funds to be transferred to MHSP to pay 80 percent of mental health services provided by MHSP for children who are eligible for both programs. Implementing this change would offset current MHSP general fund costs. Freeing up general fund may potentially: 1) fully or partially offset the $1.5 million projected general fund deficit in the mental health services program based on data through January 2000; and 2) provide more general fund to help develop community mental health services.[4]

However, transferring CHIP funds to provide mental health services through MHSP may conflict with other policy objectives. For instance, even though CHIP enrollment is lower than projected this fiscal year, coverage could be provided for a longer period of

[3] Mary Noel, CHIP Program Officer, Department of Public Health and Human Services, testimony before the Children, Families, Health and Human Services Interim Committee, February 25, 2000.

[4] The general fund deficit is published in the DPHHS budget status report estimated from January paid claims data.

time or potentially extended to more children if CHIP funds were not transferred to cover mental health services.

## Temporary Assistance for Needy Families Block Grant (TANF)

TANF funds can be used for some services related to mental health needs or state general fund expended for the Mental Health Services Plan (MHSP) may be able to be counted toward the state maintenance of effort (MOE) required to receive the TANF grant.

Final rules, published September 1999, allow TANF funds to be used for: 1) non-medical chemical dependency treatment, and room and board costs of residential chemical dependency treatment; and 2) services intended to reunify or keep families together, such as parenting skills, anger management, and budgeting. Using federal TANF funds for these purposes could provide new funding for some types of community mental health services.

MHSP expenditures may be able to be counted toward the TANF MOE since the general fund supporting MHSP pays for services for children and families with incomes under 150 percent of the federal poverty level, is a separate state funded program, and appears to meet the definition of new state spending since MHSP was implemented July 1999. However, if TANF funds were used for services, MHSP costs could not count toward TANF MOE.

MHSP expenditures may already count toward the state MOE required to draw down the $1 million federal block grant for mental health services. State expenditures for other programs (except the child care block grant MOE) cannot be counted toward TANF MOE. So the decision to use MHSP toward TANF MOE depends on several other factors: 1) how much MHSP general fund could be counted toward TANF MOE compared to the amount of the federal block grant; or 2) whether the option to transfer CHIP funds to MHSP is a superior alternative.

Using MHSP related expenditures toward TANF MOE would allow current general fund costs to be counted toward MOE without expanding state spending. The most recent budget status report prepared by DPHHS projects a general fund shortfall of about $400,000 in TANF MOE. Counting eligible MHSP costs toward MOE could help offset the MOE shortfall and potentially free up general fund to be used for innovative community mental health services.

Statutory and rule changes would be needed to use TANF funds for MHSP or to count MHSP toward TANF MOE. DPHHS would also need to amend the state TANF plan.

# INTRODUCTION

The HJR 35 subcommittee of the Legislative Finance Committee has adopted development of appropriate community mental health services as it primary study focus. Development of appropriate community mental health services is necessary to: 1) provide services in the least restrictive setting; 2) provide choice for consumers; 3) allow coordination of services to adults and children involved with more than one public entity; and 4) use limited resources most efficiently.

One of the barriers to developing appropriate community services is the inflexibility of funding sources. Since access to each funding stream depends on income, and in some cases impairment, it can be cumbersome, to fund suitable services to maintain adults and children in the community when appropriate.

## General Fund – The Ultimate Flexible Funding Source

As legislators and program administrators know, general fund provides the ultimate flexibility in funding programs. The state can tailor programs to bring about desired outcomes, within the bounds of the federal and state constitutions and statutes. However, general fund is limited and legislators balance many competing demands for general fund as well as balancing funding demands with tax rates and burdens.

Montana will be receiving funds from settlement of the national lawsuit against tobacco companies. Montana may receive as much as $70 million in the 2003 biennium.[5] Proceeds of the tobacco settlement could be used to fund new community mental health services or as a match to draw down more federal matching funds in Medicaid.

Since general fund provides great flexibility in program design, one of the purposes of this report is to identify ways to offset current general fund spending on mental health services to free up general fund to use in developing appropriate community mental health services. As noted later in the report, there are two potential federal sources that can be used to offset general fund. However, adding new federal funding sources to the mental health services system will create new complexities for providing services and administering and managing programs.

## Flexibility in Medicaid

Medicaid funds are the most significant source of funding for state administered public mental health services in Montana. However, federal participation in the cost of services (about 70 percent in Montana) comes with federal rules and restrictions governing how Medicaid funds can be spent. The twofold challenge that states face in using Medicaid

[5] $70 million is an estimate that does not take into account any offsets to settlement payments such as reductions that can occur if cigarette sales volumes decline.

funds to pay for services or programs to meet unique state needs is: 1) ensuring compliance with federal rules and regulations; and 2) avoiding greater workloads (and potentially greater state costs) to administer and manage innovative programs funded with Medicaid funds.

## State Medicaid Plans

States submit a plan explaining their Medicaid programs. The plan is reviewed and approved by the Health Care Financing Authority (HCFA), which has 90 days to review a plan once it is submitted. If HCFA requests additional information from the state in order to complete its review, a new 90-day clock starts when the state submits the additional information. There is no time limit within which HCFA must approve a state Medicaid plan. The number of 90-day clocks that can be initiated due to HCFA information queries is not limited. However, state plan reviews are usually completed within six months.[6]

States can amend their state Medicaid plans. Generally, states can (and frequently do) implement the amendment prior to final acceptance of the amendment by HCFA.[7] HCFA follows the same time schedule in reviewing and approving plan amendments as it does in approving state Medicaid plans. If HCFA does not approve an amendment that the state has already implemented, the state may be liable for repayment of the federal financial participation.[8]

## Universal Medicaid Criteria

States must offer mandatory services in their Medicaid plans and may choose to provide optional services, within federal guidelines. Eligibility is similar with mandatory coverage for some groups with some state flexibility to add optional categories of eligibility within federal guidelines.

There are federal rules regarding Medicaid service availability. Once a service is included in a state plan, it must be available statewide. That does not mean that if psychiatric services are covered by the plan and there are no psychiatrists available in Malta, for instance, that the state Medicaid program must provide psychiatric services to Medicaid eligible persons in Malta. A Medicaid service must be available to the Medicaid population in the same proportion it is available to the general population.[9]

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[6] David Selleck, Manager State Programs Branch, Region VIII, Health Care Financing Administration, personal conversation, February 23, 2000.

[7] Betty Strecker, Health Insurance Specialist, Health Care Financing Administration, Region VIII, personal conversation, February 10, 2000.

[8] David Selleck, personal conversation, February 23, 2000.

[9] Please note that some Medicaid services may not have exact private market duplicates in order to validate this federal requirement. For instance, therapeutic foster care is not a readily available service in the private market for mental health services.

Services must also be available to all eligible persons, but states can limit access (payment for services) based on medical necessity. For instance, a state may chose to cover inpatient residential psychiatric care for children as Montana does, but reimbursement for services is denied if the service is not medically necessary or is no longer medically necessary.

States cannot artificially limit access to services if a service is medically necessary and there are providers willing to supply the service. Providers meeting state criteria for participation in the Medicaid program must be allowed to participate.

## Waivers of Federal Medicaid Regulations

One way to create flexibility in the design of a Medicaid funded program is to request a waiver of federal regulations. Waivers can (and must) be used if a state wishes to: limit the availability of services; limit access to services; fund services from a capitated or case rate if consumers cannot chose among providers; demonstrate unique service models; or pay for services that are not Medicaid reimbursable. There are two types of waivers: 1) a more routine type waiver – a 1915(b); and 2) a research and demonstration type waiver – an 1115. One condition common to both waivers is that the changes resulting from waivers must be cost neutral with respect to federal financial participation.

### 1915 (b) Waiver

The most common waiver, called a 1915(b) waiver, can be used to waive such criteria as statewide availability of services and freedom of consumer choice among providers.[10] It has advantages over the 1115 waiver in that the application process is straight forward, the time period for approval or denial is regulated and it can be renewed indefinitely. The 1915 (b) waiver is somewhat limited in that it cannot be used to waive some criteria including funding restrictions, so a 1915 (b) waiver may not be able to accommodate some types of flexibility that a state may want to add to its Medicaid funded program.[11] Examples of 1915 (b) waivers that DPHHS administers are the home and community based services waivers for persons who are developmentally disabled or who are severely physically disabled. The Mental Health Access Plan (MHAP) required a 1915 (b) waiver of freedom of choice, since all Medicaid eligible participants were required to access services through a single managed care company.

[10] Mary Dalton, Chief, Medicaid Services and CHIP Bureau, Health Policy Services Division, Department of Public Health and Human Services, personal communication, February 2, 2000.
[11] Health Management Associates, "Montana Managed Mental Health Care: Program Considerations and Recommendations", September 24, 1994, p. 3.

1115 Waiver

The second, usually more complex waiver, called an 1115 waiver, is used to demonstrate a program or project that has not been tried or proposed on a wide spread basis.[12] There are two types of 1115 waivers: a waiver of Medicaid regulations only; or a waiver plus grant money. Grant money is available in defined areas of interest to HCFA and is awarded on an annual grant cycle using application criteria defined by HCFA. Projects can usually be renewed on a non-competitive basis for three years. Projects extending beyond three years must compete with new applications to extend the waiver and grant funding.[13]

The 1115 waiver of regulations only is easier to obtain than an 1115 waiver with a grant, but nearly always more complicated or time consuming than obtaining a 1915 (b) waiver. The 1115 waiver is usually required to demonstrate unique aspects of special programs. It is typical for HCFA to authorize only one of a type of demonstration waiver and not duplicate other demonstrations. The average time for review and approval of an 1115 waiver is 20 to 24 months.[14]

An 1115 waiver must demonstrate cost neutrality or savings. The waiver request (and the cost of demonstration project) must include an evaluation of results by an entity independent from the state Medicaid program. If an 1115 waiver is not cost neutral, a state may be required to repay the portion of federal Medicaid costs that were paid in excess of the program cost without the waiver.

DPHHS would have needed an 1115 waiver to implement MHAP as it was originally conceived. The original MHAP plan anticipated extending Medicaid eligibility for mental health services only to persons with incomes up to 200 percent of the federal poverty level. HCFA would not approve the waiver unless eligibility for physical health services was also included in MHAP. HCFA staff reasoned that mental health services are an optional service under Medicaid and that expansion of an optional service without a commensurate expansion of mandated physical health services was contrary to Congressional intent in establishing the Medicaid program.

Expanding Medicaid eligibility to 200 percent of poverty for mental health services would have allowed services to be funded 70 percent federal Medicaid funds and 30 percent state match instead of 100 percent general fund. Expanding Medicaid eligibility would have leveraged existing expenditures of general fund to provide mental health services to additional persons. DPHHS decided to not pursue the 1115 waiver since the general fund cost to pay for physical health services as well as mental health services would have exceeded what the executive branch planned to spend for MHAP.

[12] Cindy Smith, Health Insurance Specialist, Region VIII, Health Care Financing Administration, electronic mail communication, March 2, 2000.
[13] Health Management Associates, p. 3.
[14] Cindy Smith, personal conversation, February 29, 2000.

Although waivers can provide the most flexibility in funding unique services within Medicaid programs, designing and pursuing a waiver can be time consuming. For example, the original MHAP proposal was developed over three years.

## Prepaid Health Plans

There is another option that states can use to bring funding flexibility to Medicaid services – a prepaid health plan (PHP).[15] A PHP is a specific option available to states authorized in federal Medicaid law (42 CFR 431.54b). A PHP uses a capitated rate to reimburse a bundle of services defined by the plan. It replaces Medicaid fee-for-service reimbursement methods that otherwise probably require a waiver of federal Medicaid reimbursement criteria.

Depending on how a PHP is structured it would require a state plan amendment, but not a waiver.[16] PHPs foster flexibility in that states can make a capitated payment for a "bundle" of services and structure unique programs without a waiver.

States do not have to follow federal procurement guidelines if any willing provider can participate in the PHP. If a state wishes to limit the number of providers selected to participate in a PHP, it must follow federal competitive procurement guidelines if the services are to be funded from Medicaid funds.[17] Competitive procurement requires issuing a request for proposal and competitive bid process.

HCFA review and approval of the PHP contract is required if payments to individual providers will exceed $1 million. Otherwise, contract review by HCFA is optional. Many states prefer to have PHP contracts reviewed even if it is not required.[18]

## Services Included in a PHP

When a state uses a PHP it may include services that are in addition to those listed in the state Medicaid plan. A state can also include services that are not reimbursable under the Medicaid program, such as respite care, but the state cannot claim federal financial participation for those services.[19]

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[15] It is interesting to note that MHAP was a prepaid health plan, but required a waiver because freedom of consumer choice was restricted. The PHP alternative outlined in this report envisions a series of prepaid health plans designed to allow any willing provider to participate with consumer choice among fee for service providers and a PHP thereby avoiding the requirement of a waiver.

[16] Cindy Smith, Health Insurance Specialist, Region VIII, Health Care Financing Administration, personal conversation, February 23, 2000.

[17] David Selleck, personal conversation, February 23, 2000. Federal requirements are referenced in 45 CFR 74.

[18] Cindy Smith, personal conversation, February 23, 2000.

[19] Ibid.

## PHP and Capitation

A PHP by definition uses a capitated reimbursement method. Other service models using capitated reimbursement would require a waiver of Medicaid regulations.

The capitated rate cannot be greater than the upper payment limit. Generally, the upper payment limit is the amount that a state would have paid for Medicaid services in the fee-for-service system. Only the expenditures made for the Medicaid reimbursable services included in the PHP can be used to determine the upper payment limit and subsequently the capitation rate.

States have determined capitated rates based on actuarial analysis as did DPHHS in determining MHAP payment rates and states have determined capitated rates based on fee-for-service data compiled by state staff. HCFA reviews calculation of the upper payment limit.

As noted earlier, a PHP may contain services in addition to those authorized in the Medicaid state plan and may contain services that cannot be funded by Medicaid. If the PHP includes services that cannot be funded by Medicaid, the capitated rate cannot be increased to include federal participation in the cost of those services. If the cost of additional services must be funded either within the savings achieved by providers or the state can increase the capitation rate, but the increase must be funded from state funds.

The philosophy of a PHP is like that envisioned for MHAP and recent pilot projects undertaken by DPHHS: providing appropriate services at the appropriate time, especially appropriate services in the community, should achieve savings by preventing placement or shortening length of stay in higher end, more expensive services.

## Voluntary Participation in a PHP/Adverse Selection

If the PHP is comprehensive (includes all services) and consumer participation is voluntary, it becomes difficult to determine what the capitated payment should be. Capitation payments are based on average utilization.

Voluntary participation could create an adverse selection by Medicaid recipients. If only the "healthier" consumers select the PHP, the capitation rate might result in DPHHS paying too much for the services. If only the "most ill" consumers go to the PHP, the capitation rate will under fund the true cost of care, making financial viability of the plan unlikely.

Proponents of a voluntary participation model believe that the types of wrap around services that can be funded will be attractive enough to gain diverse membership thereby negating potential adverse selection.

## Changes Made by SB 534

The 1999 legislature enacted SB 534 to address issues related to MHAP. Depending on how a PHP is structured and how much risk is shifted to providers, it may come under the purview of the Commissioner of Insurance due to changes in SB 534. If DPHHS transfers all risk to a contractor through a capitated arrangement, the contractor must be a licensed insurer in Montana and meet financial solvency criteria. The financial solvency and licensure requirements could prevent some providers from participating in a PHP. However, as long as Medicaid beneficiaries could still receive services from other providers, or through the fee-for-service system if the PHP contractor became insolvent, then a PHP may not require that successful bidders be licensed insurance companies. The applicability of licensure to providers participating in a PHP may require additional analysis.

## PHP Could Fund Wrap Around Community Service Models

A PHP could be used to fund models that provide wrap around community mental health services. A PHP can provide funding flexibility and does not require a waiver of federal Medicaid criteria as long as: 1; 2) total payments to an individual provider participating in a PHP do not exceed $1 million; and 3) Medicaid recipients have a choice between receiving services from a PHP and fee for service providers. If any willing provider can participate in a PHP, then the state does not have to comply with federal procurement requirements.

DPHHS has already funded pilot projects that provide intensive community support services for adults and children, with federal Medicaid funds and general fund, using a modified case rate funding mechanism for the children's demonstration. A PHP could have been used to fund the pilot and demonstration projects.

## EPSDT

Some consultants who have made presentations in Montana describing wrap around service models for children have indicated that the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) benefit within the Medicaid program can be used to fund such services. EPSDT is like an entitlement within an entitlement program. If a Medicaid-eligible child needs a service that is eligible for Medicaid funding and it is the only service that can provide the medically necessary treatment, then the state must pay for the benefit even if the benefit is not included in its state plan.

However, EPSDT is limited in its ability to fund wrap around services in that it only applies to children and it cannot be used to fund services that are not eligible for federal Medicaid reimbursement such as respite care.[20] The PHP model would have more

[20] David Selleck, personal conversation, February 23, 2000.

flexibility than EPSDT because it can apply to children and adult services and can include services that are not part of the Medicaid program.

## CHIP

Children who are eligible for MHSP are most likely also eligible CHIP since both programs use the same financial eligibility criteria.[21] The reverse is not always true since children must be determined to be seriously emotionally disturbed in order to be eligible for MHSP.

CHIP provides physical and mental health coverage, but mental health services are more limited than services available under MHSP. So for a child who is eligible for both programs, once CHIP benefits are exhausted, the cost of mental health coverage shifts from CHIP to MHSP. CHIP is funded about 80 percent from federal funds with a 20 percent state match and MHSP is funded fully from the general fund, except for the federal mental health block grant that provides about $1 million.

Initially DPHHS anticipated that CHIP federal funds would be used to pay a proportionate share of all mental health services for children who were dual eligible for MHSP and CHIP. The CHIP state plan is written to allow federal CHIP funds to be used for MHSP services. [22] So DPHHS could transfer CHIP federal funds to MHSP for the cost of services provided to children who were both CHIP and MHSP eligible. The shift of CHIP funds to cover expanded mental health services under MHSP could be established as a separate carve-out program like CHIP coverage of dental services.[23]

There are funds available in the current biennium CHIP appropriation that could be shifted to MHSP. During the 1999 legislature, DPHHS estimated that it would cover 10,184 children under CHIP. Currently there are about 3,700 children enrolled, or about 37 percent of the projected number, with a projected monthly increase of 600 to 700 children. At those rates, the earliest that DPHHS would not reach its budgeted level of enrollment would be December 2000.

The decision to use CHIP federal funds for mental health services for children does have other policy considerations, however. CHIP funding is authorized for 10 federal fiscal years, with funding committed for 5 years ending in federal fiscal year 2002. States have three years after the grant year to spend CHIP for services. Shifting CHIP funds to cover mental health services might reduce the number of children that could potentially receive

[21] Both CHIP and MHSP have the same income eligibility criteria: neither has an assets or resources tests and family incomes can be no greater than 150 percent of the federal poverty level ($25,575 for a family of four - an increase of $525 from calendar 1999 to 2000). Most children who are eligible for MHSP would also likely be eligible for CHIP. The two most common restrictions are that children of state employees and families that have private insurance, which includes mental health benefits, cannot be eligible for CHIP but they can be eligible for MHSP.

[22] Mary Dalton, personal conversation, February 2, 2000.

[23] Using a separate carve out should not impact CHIP premiums or discourage private carriers from participating in CHIP.

CHIP coverage. Also, it is not known if federal authorization and funding for CHIP will be extended or what new conditions might accompany CHIP reauthorization.

### Mental Health Services General Fund Budget Shortfall

Shifting CHIP funding to MHSP is raised because: 1) it represents a way to offset general fund costs; and 2) it will be discussed in a report prepared for the March 9, 2000, meeting of the Legislative Finance Committee (LFC) with regard to the most recent DPHHS status report. It is important that the LFC subcommittee studying public mental health services hear the issue too.

Shifting CHIP federal funds to cover MHSP costs would allow DPHHS to either fully or partially offset the January budget status report that projects a $1.5 million general fund shortfall in the mental health services budget administered by Addictive and Mental Disorders Division (AMDD). Using CHIP federal funds to offset general fund costs might also allow AMDD to increase flexibility for funding community mental health services, in keeping with the primary purpose or this report, if the CHIP offset were greater than the projected general fund deficit.

DPHHS has not indicated how it will manage the projected general fund shortfall in mental health services. Language in House Bill 2 (HB 2), the general appropriations act, states: "In accordance with 17-8-103, the department may not spend more general fund money for mental health managed care services than was appropriated in this act." The amount of the general fund appropriated for mental health managed care services is not explicitly listed in HB 2. However, the Fiscal Report prepared by the Legislative Fiscal Division identifies the total general fund appropriated for all mental health services, including program administration, of $44.6 million in fiscal 2000 and $45.5 million in fiscal 2001. The legislature expected, based on testimony from DPHHS staff, that DPHHS would implement a new mental health managed care system beginning fiscal 2001. After the legislature adjourned DPHHS announced that a transition to mental health managed care would be gradual and build on the fee-for-service system that it had implemented.

## Temporary Assistance for Needy Families Block Grant

Final regulations for the Temporary Assistance for Needy Families (TANF) Block grant became effective October 1, 1999. The final regulations placed more restrictions on the use of unspent federal TANF funds carried over from previous grants, while at the same time increased the flexible use of TANF funds for services that fit the definition of "non assistance." The final regulations give states and federally recognized Indian Tribes the authority to use federal welfare funds "in any manner that is reasonably calculated to accomplish the purpose" of the new program. It provides states broad flexibility to set eligibility rules and decide what benefits are most appropriate. These changes would allow TANF funds to be used for some types of mental health related services for

families and children. If TANF funds are not combined with MHSP, general fund supporting MHSP services for some families and children may be able to be counted toward the TANF MOE.[24] Counting MHSP expenditures toward the TANF MOE could free up general fund to be used for other priorities or purposes, including expansion of mental health services or offset of the projected general fund shortfall.

TANF and MOE funds must be used to serve needy families, if services fall within two of the purposes of TANF. States must apply an income eligibility standard to determine whether a family meets the definition of needy, but states may define eligibility levels. It appears that states can define needy at income levels up to 200 percent of the federal poverty level.[25]

## MHSP Counted Toward TANF MOE

Federal TANF regulations do not explicitly define medical services, but do consider medications, physician services, nurses, and health insurance premiums as medical services. Among services considered non-medical are referral services, assessments, case management, and services rendered by non-medical professionals such as social workers.[26] Within these broad guidelines, states may define what constitutes medical services. The definition of medical services is important because although federal TANF funds cannot be used to pay for medical services, MOE funds spent in a separate state program, such as MHSP, can be used to pay for medical services.

State MOE funds that have not been commingled with federal TANF funds may be used "to pay for medical services (e.g. for treatment of substance or alcohol abuse not paid by Medicaid) or to provide medical coverage for families that lack medical benefits."[27] MHSP meets several federal requirements necessary to be counted toward TANF MOE. It is a separate state program (separate from the TANF program) that serves needy families (those with incomes less that 150 percent of the federal poverty level), and the expenditures would meet the TANF "new spending" test. If the TANF state plan were amended to include MHSP services, it is possible that a portion of the general fund expended in MHSP could be counted toward TANF MOE.

## Projected General Fund Shortfall

The most recent budget status report prepared by DPHHS anticipates general fund shortfalls in the TANF MOE of about $400,000 and in mental health services of about

[24] MOE is the amount that the state must spend to drawn down the TANF block grant. It is a fixed amount based on state expenditures in federal fiscal year 1994. The minimum MOE that Montana must pay is about $15 million.

[25] Mark Greenburg and Steve Savner, Center for Law and Social Justice, "The Final TANF Regulations: A Preliminary Analysis", May 1999, p. 15.

[26] Sheri Steisel, National Conference of State Legislatures, personal communication, February 17, 2000.

[27] Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance. "Helping Families Achieve Self-sufficiency", no date, p. 20.

$1.5 million. Using MHSP expenditures toward the MOE would help resolve the projected MOE shortfall and depending on the amount of MHSP expenditures that could be counted toward TANF MOE, it could free up general fund to offset the mental health services shortfall.

## MOE for Federal Mental Health Block Grant/CHIP Funds

It should be noted that state funds used to match or draw down other federal funds cannot be counted toward TANF MOE, with the exception that state MOE for the child care block grant can be counted toward TANF MOE. There are two issues related to the "double counting" of state funds for federal grants.

The Mental Health Services Block Grant (about $1 million this year) also requires a maintenance of effort. States must spend an amount at least equal to the average over the previous two state fiscal years. Estimates of the amount of MHSP spending that potentially could be counted toward TANF MOE are not available. Until policy makers have that information it is not possible to evaluate whether general fund that could be counted towards TANF MOE would more than offset the mental health services block grant amount.

If MHSP general fund were to be used to match CHIP funds, it could not also be used to draw down TANF.

## Federal TANF Funds for Mental Health Services

In addition to counting MHSP expenditures toward MOE, federal TANF funds may be used to provide "appropriate counseling services (e.g. mental health services, anger management counseling, non medical substance abuse counseling services, including room and board costs at residential treatment programs) to family members with barriers to employment and self-sufficiency."[28] Some services such as marriage counseling can be funded from TANF regardless of need.[29] States expenditures to provide non-medical substance abuse or alcohol abuse services, including room and board costs at residential treatment programs may also be counted toward the MOE.[30]

## Creative Uses of TANF in Other States

The rules and regulations of the TANF program are complex; therefore, creative uses of TANF and MOE funds require that programs be carefully crafted to assure compliance with all applicable regulations.

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[28] Ibid.
[29] Sheri Steisel, personal communication, February 17, 2000
[30] Department of Health and Human Services, no date, p. 20.

Other states are using TANF and MOE funds to meet substance abuse and mental health needs of eligible families. Oregon developed a substance abuse treatment program through local community colleges. North Carolina placed substance abuse professionals in county offices to help identify clients with substance abuse problems. Michigan has instituted a pilot project in five counties where all applicants and recipients are subject to a drug test and persons who test positive will be assigned to treatment programs.[31]

## Implications of Using TANF and MOE Funds

The primary purpose of this report is increasing the flexibility in funding for mental health services. Introduction of TANF funds or tracking MHSP expenditures that could be MOE related will make administration of funding streams more complex than the current funding structure. However, accessing TANF funds may provide a funding source for services that currently cannot be provided due to funding limitations, or counting MHSP toward MOE could help solve projected general fund shortfalls in mental health services and MOE. Depending on how much MHSP general fund cost could be counted towards TANF MOE, general fund could be freed up to use for development of appropriate community mental health services. Additionally, if it were advantageous to use MSHP toward TANF MOE, it could mean that DPHHS may not be able to accept the Mental Health Services Block Grant.

## Statute and Rule Changes Necessary

It may require changes to state statute and rule to use TANF funds for mental health services or to count MHSP expenditures toward TANF MOE. DPHHS could not institute some of the uses suggested in this report without legislative authorization.

# COMPLIANCE WITH FEDERAL MEDICAID CRITERIA

The resolution authorizing the interim legislative study of public mental health services also directed the LFC to undertake certain types of oversight as part of its interim study. Among several items enumerated in HJR 35, the legislature directed that the study undertake a: "review of the Department of Public Health and Human Services staffing levels, contract auditing and compliance capabilities and performance, and any imposition of sanctions." While federal agencies have not raised compliance issues or imposed sanctions, the manner in which mental health services pilot and demonstration projects have been structured, the types of services reimbursed and providers selected may have violated federal Medicaid criteria and federal procurement policies.

[31] Jack Tweedie, Dana Reichert and Sheri Steisel, National Conference of State Legislatures, "Challenges, Resources, and Flexibility; Using TANF Block Grant and State MOE Dollars", September 1999.

There are two separate issues related to the Medicaid compliance. The first is funding pilot or demonstration projects that limit provider participation and the number of service slots without receiving a waiver of federal Medicaid criteria and without complying with provisions of federal procurement guidelines. The second issue is the status of two pilot and demonstration projects currently funded from general fund and Medicaid funds.

The Medicaid compliance issue focuses on the legality of using Medicaid funds to pay for limited scope pilot projects. The report does not evaluate the pilot and demonstration projects that are currently being funded. Comments on compliance with federal Medicaid criteria should in no way be construed as bearing on the worthiness or outcomes of the pilot projects.

## Pilot/Demonstration Project Compliance with Universal Medicaid Criteria

Three primary federal Medicaid criteria - statewide availability of services, participation of any willing provider that meets state Medicaid certification criteria, and freedom of provider choice - limit state options to pursue demonstration or pilot programs without a waiver of applicable federal rules. Federal regulations regarding reimbursement for services also limit how states may contract for the provision of services if any willing provider is prevented from participation and what services can be funded from Medicaid funds.

Programs or contracts that artificially restrict - 1) availability of services to only selected areas of the state; 2) the number of providers authorized to provide the service; or 3) service availability to a select group of Medicaid eligible persons - are almost certainly a violation of federal Medicaid criteria. The state can undertake projects that restrict provider participation or number of services without a waiver if the cost of the projects is funded entirely from general fund. However, if federal Medicaid funds are used to support projects that restrict statewide availability of services, freedom of choice, or participation by willing providers, the state could be at risk of noncompliance with federal Medicaid criteria. Although rare, a state can be required to repay the cost of federal financial participation in all or part of its Medicaid program if it is found to be out of compliance and refuses to bring its program into compliance with federal regulations.[32]

## DPHHS Policy on Pilot and Demonstration Projects

DPHHS defined a process by which demonstration and pilot projects would be proposed and evaluated. The policy clearly explains that there are no funds appropriated specifically for such purposes and that the policy should not be construed as an invitation for or solicitation of pilot and demonstration proposals.

[32] David Selleck, personal conversation, February 23, 2000.

The process document does not mention federal procurement requirements or waiver requirements that may necessary to bypass selected federal Medicaid criteria in order to fund pilot or demonstration projects with Medicaid funds. DPHHS staff indicate that they would pursue pilot and demonstration projects only upon recommendation by the Mental Health Oversight Advisory Council.[33]

The pilot and demonstration policy is raised in this report because DPHHS does not believe that it has violated federal Medicaid criteria by limiting provider participation in one of the pilot projects it has pursued, but is less comfortable in assessing the demonstration project.[34] The policy may indicate that DPHHS will continue to use federal Medicaid funds for pilot and demonstration projects that limit participation by willing providers and forego statewide availability of services by limiting the number of services or service slots. If DPHHS uses federal Medicaid funds for pilot and demonstration projects without obtaining waivers of federal criteria and without following federal procurement procedures, there will be a greater risk of attracting HCFA oversight attention and a potential determination of noncompliance with federal Medicaid program criteria.

## Potential Repercussions

As noted previously, a state can be fined all or part of the federal financial participation in its Medicaid program if it is found to be out of compliance with federal regulations, although assessment and enforcement of such fines seems to be rare. Compliance is prospective, meaning that a state will be allowed a period of time to correct errors, which can include presenting an option to the next legislature.[35]

## Operation of Specific Pilots/Demonstrations

DPHHS is currently operating two pilot/demonstration projects funded from Medicaid and general fund: 1) two Programs for Assertive Community Treatment (PACT) in Helena and Billings for adults who have a serious and disabling mental illness; and 2) a Family Support Services project for children. DPHHS has indicated that it will continue PACT and is planning on statewide implementation of the model. It recently authorized continued operation of the Family Support Services through the end of March 2000. The demonstration project was originally supposed to end February 29. If the Family Support Services demonstration project is not continued about 30 families will lose access to the intensive services offered by the demonstration project.

[33] Randy Poulsen, meeting with Lois Steinbeck, Taryn Purdy, David Niss, and Rusty Redfield, March 6, 2000.
[34] Ibid.
[35] Ibid.

## PACT

DPHHS reviewed its proposal to implement PACT with federal HCFA staff and believe that HCFA approved its start up plan to add PACT services gradually.[36] It is unclear whether HCFA staff understood that providers would be selected by DPHHS without a competitive process. What remains undetermined is how HCFA will view statewide implementation and addition of new providers. DPHHS staff believes that it may have the ability to target and recruit PACT providers in specific areas of the state and be in compliance with Medicaid criteria. However, only HCFA staff can provide the definitive answer as to what process they consider to be in compliance with statewide availability of services and provider recruitment.

In order for PACT to be implemented statewide, DPHHS will most likely need to include PACT provider participation criteria in state rule as it does for all Medicaid service providers not subject to federal criteria. DPHHS must also determine what rates will be paid or how rates will be determined so that prospective providers know what the program revenue may be compared to program costs.

DPHHS is considering a 2003 biennium budget proposal for PACT implementation. The draft proposal requests start up funds for additional PACT services. DPHHS does not anticipate requesting a waiver to limit PACT slots so the PACT program would become an entitlement for those persons needing that level of service and in locations where willing providers would offer PACT services.

## Family Support Services

DPHHS did not review implementation of the family support services demonstration project with HCFA and in not certain what HCFA may determine with respect to adherence to Medicaid program criteria and compliance with federal procurement requirements. DPHHS staff are less certain that this demonstration project could be determined to be in compliance with federal Medicaid criteria.[37]

# APPLICABILITY OF SB 534 TO PILOT AND DEMONSTRATION PROJECTS

The PACT reimbursement method shifts risk to the providers and may fall under the requirements of SB 534 for provider licensure as an insurance carrier. The PACT contract includes a cost based method of reimbursement that requires providers reimburse DPHHS if the cost of services is less than the amount paid for PACT services, but PACT providers do not receive additional compensation from DPHHS if reimbursement is too low. So PACT contracts as currently written may transfer risk of

[36] Ibid.
[37] Ibid.

reimbursement shortfalls to the providers. It is unclear whether the provisions of SB 534 apply to the PACT program and the cost based method of reimbursement described in the contract.

# WHERE DO WE GO FROM HERE?

This report identified a model to make Medicaid funding more flexible – the PHP – and described the conditions under which a PHP can be established with minimal or no federal review. The report also identified several ways to offset current general fund spending to: 1) free up more general fund to be used for unique mental health community services and programs; and 2) potentially negate projected general fund shortfalls in mental health services. However, adding new federal funding sources to free up general fund and use it most efficiently (spending federal funds for mental health services or counting MHSP costs toward TANF MOE) also introduces more complexity into funding mental health services, which is contradictory to the first purpose of the report. Finally, in keeping with the oversight functions assigned to this study, an issue of compliance with federal Medicaid regulations has been raised. So what can the HJR 35 subcommittee do with this information?

## More Questions than Answers

In some ways this report has raised more questions than it has provided answers. One outcome is the potential applicability of a PHP to provide enhanced Medicaid funding. Carefully structured, PHPs can be designed to pay for a bundled set of services using a capitated rate without requiring a waiver. As long as any willing provider can participate a state would not have to adhere to federal competitive procurement requirements. Outstanding issues may remain with respect to:

- applicability of some of the changes made by SB 534 regarding insurance licensure of providers participating in a Medicaid mental health managed care program;
- necessity of contracting with an actuary to determine capitated rates;
- actions that should be considered to prevent or minimize adverse selection;
- desirability of a voluntary federal review for PHP contracts not expected to exceed $1 million in payments to providers; and
- desirability and workload impact of administering and managing PHPs within a fee-for-service system.

### Legislative Action

The HJR 35 subcommittee has two meetings to pursue additional issues, begin formulating solutions, and complete its work. The next meeting will be May 10 and 11 with the final meeting in August.

The HJR 35 subcommittee could direct staff to prepare an analysis of the applicability of SB 534 to PHPs (and potentially other reimbursement and service models currently used by DPHHS) in order to identify any potential conflicts in using PHPs to fund wrap around community mental health services.

The HJR 35 subcommittee could also request that DPHHS review the PHP option and comment on whether a PHP would be a useful tool in funding innovative community services. DPHHS could be asked to comment on potential statutory changes that might be needed if it were to use PHPs to fund services or what legislative direction it would need to do so.

The HJR 35 subcommittee may not be able to determine whether it is necessary for DPHHS to contract with an actuary to determine PHP reimbursement. The HJR 35 subcommittee could direct staff to monitor the issue and prepare options for consideration at the August meeting.

## CHIP and TANF

It seems clear that some current MHSP general fund spending can be offset by federal CHIP funds. Some of the MHSP general fund expenditures might be able to be counted toward the state TANF MOE. If MHSP costs were not counted toward TANF MOE, then TANF funds could be used to offset some MHSP costs and could also be used to provide additional services, particularly those related to chemical dependency.

However, despite these issues, questions remain:

- If MHSP expenditures can count towards TANF MOE, what are the potential general fund efficiencies and savings?
- How much general fund could be offset through transfers of federal CHIP and TANF funds to MHSP?
- If CHIP funds are transferred, how many children would not be covered by CHIP that potentially could have been?
- What types of additional services, such as chemical dependency services, can be funded from TANF and how many people would benefit from such a program?
- What are the resulting workload and added complexity versus the value of added services and potential general fund offset?
- If TANF funds are transferred to MSHP or used for additional mental health related services, what priority should be placed on these expenditures versus other priorities for spending TANF funds?
- What changes are necessary to statute and rules in order to use TANF funds for mental health services?
- What types of innovative community services could potentially be funded with general fund savings?

Because these issues are complex, legislative staff needs to do further analysis and research, in cooperation with DPHHS staff, to answer the above questions. Additional analysis will help flesh out potential recommendations for legislative action.

The HJR 35 subcommittee needs to decide which issues should receive additional analysis, in addition to any questions it has,. Once the subcommittee has identified priority issues, staff could research those issues for presentation at the May meetings.
The HJR 35 subcommittee could also request that DPHHS staff assist legislative staff in evaluating funding issues. DPHHS staff assistance could provide benefits in helping identify DPHHS areas of concern and impacts to workloads if federal funding is used to offset MHSP general fund costs. Participation by DPHHS staff can also have benefits in helping to clearly define issues and potential solutions for legislative consideration, much the same as the process followed during joint appropriation subcommittee hearings and deliberations.

## Medicaid Compliance Issue

The final issue raised by this report is compliance with federal Medicaid criteria with respect to the pilot and demonstration projects funded with general fund and Medicaid funds. It should be noted that DPHHS believes it is not out of compliance with federal Medicaid criteria in relation to one pilot project currently operating and may not be if it funded more pilot and demonstration projects in the same manner.

DPHHS has already worked with HCFA staff in implementing the PACT pilot program. HCFA will also be the final authority on whether federal Medicaid criteria are satisfied with respect to implementation of pilot projects. DPHHS staff has indicated its willingness to work in cooperation with legislative staff and HCFA in order to answer questions of Medicaid compliance. The HJR 35 subcommittee could consider requesting such cooperation and a report on research outcomes at its next meeting.

## PACT Pilot Options/Statewide Implementation

Options that the HJR 35 subcommittee can consider with respect to the current PACT pilot and statewide implementation planned by DPHHS are: 1) request that DPHHS estimate the cost to implement PACT statewide; or 2) request that DPHHS apply for a waiver to limit the number of service slots available and gradually implement PACT statewide.

The potential DPHHS budget proposal to implement PACT statewide may not anticipate the full cost of creating a true entitlement for PACT services. The HJR 35 subcommittee may want to request that DPHHS estimate the cost of PACT services if PACT were incorporated into the state Medicaid program as an entitlement to eligible persons needing that level of service. The HJR 35 subcommittee may also request that DPHHS provide preliminary outcome measures from the PACT pilots. The HJR 35

subcommittee could then evaluate the merits of statewide implementation comparing costs to expected outcomes.

The second option would be to request that DPHHS apply for a waiver to limit the number of PACT slots available statewide. This option initially imposes a higher workload on DPHHS staff, but it would have the advantage of legislative review and oversight of program expansion, similar to oversight of the home and community based waiver services for persons who are developmentally disabled or who are severely physically disabled.

## Future Pilot and Demonstration Programs

The HJR 35 subcommittee could consider several options with respect to funding future pilot and demonstration projects. The subcommittee could request that: a) DPHHS follow a competitive bid process if it limits provider participation and make a written legal determination that a waiver of certain Medicaid criteria such as statewide availability of services is not necessary prior to pilot approval; or b) fund all pilot projects from funding sources other than Medicaid funds.

### Competitive Bid Process/Waiver

If DPHHS follows a competitive bid process and researches waiver necessity, its ability to react quickly to initiatives will be impaired. This approach also imposes more workload on DPHHS staff. However, it does include routine application of two very important compliance issues with respect to federal Medicaid participation in the cost of services.

### Fund all Pilots with Funds Other Than Medicaid Funds

The option to fund pilot programs from the general fund or other sources would greatly limit DPHHS ability to fund pilot projects. However, using a funding source other than Medicaid greatly enhances DPHHS flexibility to design and administer pilot programs.

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